Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 29, 2019	2019_767643_0017	032794-18, 006330-19, 008511-19, 008574-19, 010080-19	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Kennedy Lodge
1400 Kennedy Road SCARBOROUGH ON M1P 4V6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ADAM DICKEY (643), BABITHA SHANMUGANANDAPALA (673)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 13-17, 21 and 22, 2019.

The following Complaint intakes were inspected during this inspection:
Log #008574-19 - related to alleged abuse;
Log #006330-19 - related to alleged abuse and improper transferring; and
Log #032794-18 - related to withholding application for admission.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Log #008511-19, CIS #2654-000005-19 - related to alleged abuse; and
Log #010080-19, CIS #2654-000007-19 - related to improper treatment.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Workers (SW), Local Health Integration Network (LHIN) representatives, residents and family members.

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, staff training
records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident.

As a result of identified noncompliance for resident #015 the sample of residents reviewed was expanded to include resident #002.

Observations by the inspector showed PSW #109 entering resident #002's room with a specified transferring device. PSW #109 prepared the resident with an identified sling type and requested another staff member to assist with resident #002. RN #110 entered the room and instructed PSW #109 this was the incorrect sling for the resident as they were using the above specified transferring device. PSW #108 entered the room and instructed PSW #109 that the initial sling type was correct, however the resident no longer used the above specified transferring device as they were unsafe. The inspector observed a logo placed above resident #002's bed showing a second identified transferring device.

Review of resident #002's care plan showed staff were instructed to use the first above specified transferring device with two staff members for both transferring and toileting. Review of progress notes showed resident #002 was assessed by PT #113 and indicated the resident required the second above mentioned transferring device.

In an interview, RN #110 indicated that resident #002's written plan of care instructed staff to use the first above specified transferring device for transferring and toileting. RN #110 reviewed resident #002's assessments and indicated that they had recently been assessed to require a second identified transferring device, and registered staff would be expected to revise the written plan of care when the transfer status changed. RN #110 acknowledged that as the transfer logo showed the second identified transfer device and the written plan of care showed the first specified transfer device the transfer method was unclear for staff who provided direct care to resident #002.

In an interview, the DOC indicated that when an assessment of a resident's transfer status was completed and transfer method changed, registered staff would be expected to change the written plan of care to reflect the change. The DOC acknowledged that the plan of care did not provide clear directions regarding resident #002's transfer status. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #016 was protected from abuse.

Physical abuse as outlined in section 2. (1) of the Regulation (O.Reg 79/10) means the use of physical force by anyone other than a resident that causes physical injury or pain.

An anonymous complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) which alleged that a resident in a specified room and bed number was pulled by a member of the staff of the home which resulted in the resident falling and experiencing pain. In an interview with the complainant it was indicated that this incident was reported to the evening manager and should have been considered abuse.

Review of resident #016's progress notes showed that on an identified date, the resident was assisted in a specified area of the home by a PSW and RPN #101 to stand and the resident was lowered to the floor. Resident #016 had complained of pain following the incident and a specified analgesic medication was administered.

In an interview, resident #016 stated that when the incident happened they were seated in an identified resident home area and the person who gives the medication forced them

to get up and they had fallen. Resident #016 indicated that the staff member pulled them and forced them to get up and had pain as a result of the fall. Resident #016 indicated that the staff member wanted the resident to come to the dining room at the time of the incident.

In an interview, PSW #100 indicated that on the above identified date, they had assisted resident #016 with a specified activity of daily living (ADL), and came back to see if the resident had finished to come to the dining room. PSW #100 indicated that they reported to RPN #101 that resident #016 had not completed the identified ADL and would come to the dining room later. PSW #100 indicated that RPN #101 told them they had to get the resident up and both staff attempted to assist resident #016 to stand, and resident #016 said no. PSW #100 indicated that RPN #101 made another attempt to pull resident #016 up when they fell.

Interview with RPN #101 did not corroborate these accounts, indicating that on the above identified date they had been assisting PSW #100 with resident #016 when they lost balance and were lowered onto the floor. RPN #101 denied pushing or pulling resident #016.

Review of the home's investigation notes showed that resident #016 had been interviewed the day after the incident, and indicated that they had been pushed by the person who usually gives them medication onto the floor. Resident #016 indicated that they experienced pain as a result. PSW #100 was interviewed five days after the incident, and indicated that RPN #101 pulled resident #016, which caused the resident to fall and experience pain.

In an interview, the DOC acknowledged that in the above accounts physical force was applied to the resident which was not necessary, and caused the resident to experience pain. The DOC acknowledged that based on these findings this constituted abuse of resident #016. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident that resulted in harm had occurred immediately reported the suspicion and the information upon which it was based to the Director.

In an interview, PSW #105 indicated that they had spoken with resident #016 on an identified date following a fall incident. PSW #105 indicated that the resident reported to them that they were pushed causing them to fall. PSW #105 indicated that they had reported to ADOC #103 on the same day that the resident had told them they were pushed by a staff member.

In an interview, ADOC #103 indicated that PSW #105 had reported to them that resident #016 told them that they were pushed by a staff member, but it was unclear which staff member was involved. ADOC acknowledged that if a resident reported they were pushed by a staff member this would be considered an allegation of abuse.

Review of the home's investigation notes showed that resident #016 had been interviewed by management on the following day and indicated that they had been pushed by the person who usually gives them medication onto the floor. Resident #016 indicated that they experienced pain as a result. PSW #100 was interviewed as part of the investigation and indicated that RPN #101 pulled resident #016 which caused the resident to fall and experience pain.

In an interview, the DOC indicated that they became aware of the incident the following day, and that ADOC #103 should have initiated an investigation and reported the allegation to the Director. The DOC indicated that they had conducted an investigation into the incident, and that the resident's account indicating they were pushed which resulted in a fall pain would be considered an allegation of abuse. The DOC acknowledged that the allegation of abuse was not immediately reported to the Director and subsequently submitted a CIS after discussing the incident with the inspector. [s. 24. (1)]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect improper or incompetent care of a resident that resulted in harm had occurred immediately reported the suspicion and the information upon which it was based to the Director.

Review of resident #015's plan of care showed that they required the use of specified transferring device. Resident #015 required the assistance of two staff members for assistance with transferring. Review of resident #015's progress notes showed that on an identified date staff reported that the resident sustained an injury when being transferred. Upon assessment two specified injuries were noted causing skin impairment.

Review of the home's investigation notes showed that on the above identified date resident #015 was transferred by PSW #102 alone using a manual transfer method when the resident sustained the above injury. No CIS report was found related to this incident.

In an interview, the DOC indicated that PSW #102 had transferred resident #015 alone, without the use of the specified transfer device. The DOC indicated that this improper

transfer constituted improper or incompetent care and resulted in harm to resident #015. The DOC acknowledged that this incident had not been immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; and
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting residents.

A complaint was submitted to the MOHLTC from resident #015's family member related to two incidents in which the resident was injured. In an interview, the complainant indicated that in the first incident in an identified month, resident #015 sustained an injury which caused skin impairment while being transferred by staff. The complainant indicated that the home investigated the incident and concluded a staff member had transferred resident #015 improperly which resulted in the injury.

Review of resident #015's plan of care showed that they required the use of a specified transferring device. Resident #015 required the assistance of two staff members for assistance with transferring. Review of resident #015's progress notes showed that on an identified date staff reported that the resident sustained an injury which resulted in skin impairment.

Review of the home's investigation notes showed that on the above identified date, resident #015 was transferred from bed to chair by PSW #102 alone using a manual transfer method when the resident sustained the above injury. In an interview, PSW #102 indicated that resident #015 was to be transferred by two staff members using a specified transfer device. PSW #102 confirmed the findings of the home's investigation which concluded that they had transferred resident #015 alone and did not use the transferring device as indicated in the resident's plan of care.

In an interview, the DOC indicated that it was the expectation of the home that staff follow the resident transfer logo and plan of care when assisting residents with transferring. The DOC indicated that PSW #102 admitted to transferring resident #015 alone, and without using the specified transferring device which resulted in injury. The DOC acknowledged that PSW #102 had not used safe transferring techniques when assisting resident #015. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 5th day of June, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.